DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185236	A. BUILDING _____ B. WING _____	08/27/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWENSBORO PLACE CARE AND REHABILITATION CENTER	1205 LEITCHFIELD RD. OWENSBORO, KY 42303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 444	Continued From page 6 did not realize what she had done until it was too late. No further explanation was provided other than she did not usually do wound care and catheter care all at one time. An interview with CNA #1, on 08/27/10 at 11:00 AM, revealed she had washed her hands in the shower room on the hallway prior to entering the resident's room and after exiting from the resident's room; however, no handwashing was completed during provision of care while in the resident's room. An interview with the Director of Nursing (DON), on 08/27/10 at 2:00 PM, revealed she expected the staff to wash their hands after entering a resident's room to provide care and prior to leaving the resident's room. Additionally, handwashing was to be completed between a dressing change and catheter care. A review of the facility's policy/procedure "Hand Hygiene" (undated) revealed, "touching blood, body fluids, secretions, excretions, contaminated items, immediately after gloves are removed, between resident contacts and when otherwise indicated to avoid transfer of microorganisms to other residents or environmental surfaces. It is necessary to wash hands between tasks and procedures on the same resident to prevent cross-contamination of different body sites."	F 444		
F 502 SS=D	483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.	F 502	It is the intent of this facility to provide the best possible care to all our residents and to insure laboratory services are provided in a timely manner. Resident #2 was assessed on 8/24/2010 and no signs or symptoms of a urinary tract infection were noted. All residents have the potential to be affected by the cited practice.	10/1/10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185236	A. BUILDING _____ B. WING _____	08/27/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWENSBORO PLACE CARE AND REHABILITATION CENTER	1205 LEITCHFIELD RD. OWENSBORO, KY 42303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 502	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined the facility failed to provide timeliness of laboratory services for one resident (#2), in the selected sample of 24. A urine culture result was not provided to Resident #2's physician within the timeframe normal for appropriate intervention. Findings include: A record review revealed Resident #2 was admitted to the facility on 09/15/09 with diagnoses to include Paralysis Agitans, Type II Diabetes with Neuropathy, Gastroparesis, Functional Urinary Incontinence, Hypopotassemia, Hyperlipidemia, Unspecified Essential Hypertension. A review of a physician's order, dated 07/24/10, revealed a standard lab order to obtain urine for a urinalysis (UA) with culture and sensitivity (C&S). Further record review revealed results of a UA were collected on 07/24/10 with C&S results pending. No C&S results were found in Resident #2's record during the survey process. Interviews with Licensed Practical Nurse (LPN) #1, on 08/26/10 at 10:20 AM and at 2:20 PM, revealed the normal procedure for obtaining laboratory services on the weekend was to send the specimen to the hospital lab. All ordered labs were supposed to be placed on the facility's lab tracking record, located at the nurses' station, for follow-up. She further revealed she received results of the UA from the hospital lab on 07/25/10 and notified the physician. An order was received to notify the Advanced Registered Nurse Practitioner (ARNP) to take care of it on the	F 502	Labs, including those on the weekend, will be placed on the shift report and the laboratory tracking log. Both will be reviewed in the morning Clinical Stand Up Meeting and the afternoon Clinical Stand Down Meeting. Weekend Supervisors will monitor shift reports and the Laboratory Tracking Logs to ensure lab reports are received and follow up is performed. Staff members received re-education training on 8/26/2010 by SDC and on 9/9/2010 by the Director of Nursing and the Administrator regarding the procedures for monitoring when lab results are received, when the physician is notified and any orders are obtained, notification of the family/RP, and placement on the 24-hour Report of Residents' Change of Condition and the facility laboratory tracking log to ensure follow up on all labs. The DON will monitor compliance with the facility procedures for the 24-hour Report of Residents' Change of Condition and the Laboratory Tracking Log 5 times per week for four weeks during the standup process and report the findings monthly for three months to the Performance Improvement (QA) Committee. Any issues will be addressed through a new or revised improvement plan.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185236	A. BUILDING _____ B. WING _____	08/27/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWENSBORO PLACE CARE AND REHABILITATION CENTER	1205 LEITCHFIELD RD. OWENSBORO, KY 42303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 502	Continued From page 8 following Monday. She stated, " I don't remember putting the lab order on the lab tracking record and to be honest, I may have forgotten to." She revealed she could not find the results of the C&S in the resident's record. Additionally, there was no evidence in the resident's record that follow-up had been completed by the ARNP. An interview with the ARNP, on 08/26/10 at 11:00 AM, revealed she was in the facility on 07/26/10 and wrote on the UA results to obtain a C&S. She stated, "I typically write an order on the C&S itself; however, if no orders were needed, I would have just initialed and dated that I had seen the results." She further revealed after reviewing the results of the C&S, she would have treated Resident #2, because there were four different antibiotics that could have been used for Resident #2's urinary tract infection. An interview with the Director of Nursing (DON), on 08/27/10 at 9:36 AM, revealed all nursing wings were to use the lab tracking record to follow-up with the ordered labwork. The charge nurses' were responsible for updating the lab tracking record. She stated there were no in-services completed to ensure the nursing staff was educated, and there was no specific policy regarding labwork. She further revealed she expected the nurses to use the lab tracking record to follow-up with ordered labwork.	F 502		